

EFMB Test Score Sheet TCCC — PERFORM A TACTICAL COMBAT CASUALTY CARE PATIENT ASSESSMENT <small>(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)</small>		
CANDIDATE'S RANK AND NAME		CANDIDATE #
TASK: PERFORM A TACTICAL COMBAT CASUALTY CARE PATIENT ASSESSMENT.		
CONDITIONS: Given multiple trauma casualties in a simulated combat environment and necessary equipment to perform applicable performance steps and measures.		
STANDARDS: Perform all steps and measures IAW the concepts and principles of Tactical Combat Casualty Care and the EFMB Program without causing further injury to the casualties.		
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.		
PERFORMANCE STEPS/MEASURES	GO	NO-GO
NOTE: Performance steps/measures that are evaluated in other EFMB TCCC tasks (i.e. Control Bleeding Using a Tourniquet task) will not be marked as a NO-GO on this task as long as they were attempted at the appropriate phase in the CTL. Performance of a step/measure during the wrong phase (i.e., splinting a fracture in the care under fire phase) or not performing at all will be marked as a NO-GO on this task.		
1. Perform care under fire procedures.		
a. Take cover. Return fire as directed or required before providing medical treatment.		
b. Direct the casualties to return fire, if able.		
c. Determine the scene safety/security.		
NOTE: Despite fire superiority being gained during the care under fire phase of care, it does not mean that the enemy threat has been eliminated. You must exercise caution when maneuvering to casualties utilizing available cover, concealment, and suppressive fire. If the tactical situation permits have the casualties move to your position exercising the same caution.		
NOTE: You must determine the relative threat of the tactical situation versus the risk to the casualty. Can you remove the casualty to a place of relative safety without becoming a casualty yourself? Is the casualty safer where he is? If possible, seek assistance from your leader.		
d. Determine the number and location of the injured and severity of their injuries (Evaluated IAW Triage Casualties task).		
e. Direct team members/combat life savers to assist, if available.		
NOTE: For EFMB testing purposes, the candidate cannot direct other individuals or a casualty to perform tasks that he is being evaluated on. This is also applicable for other performance steps/measures within this task. For example, the candidate cannot direct a team member to control bleeding using a tourniquet and only check that it was applied correctly. The candidate must be evaluated on performing each of the TCCC tasks at least once.		
f. Assess the casualties for life threatening extremity hemorrhage.		
NOTE: Once fire superiority has been gained begin assessing and treating life threatening hemorrhage.		
(1) If the casualty is unresponsive or unable to move and has severe extremity bleeding, administer life-saving hemorrhage control before moving the casualty.		
(a) Use a tourniquet for hemorrhage that is anatomically amenable to tourniquet application (Evaluated IAW Control Bleeding with Tourniquet task).		
(b) For hemorrhage that cannot be controlled with a tourniquet, apply a hemostatic dressing (Evaluated IAW Control Bleeding with Hemostatic Device task).		
(2) Direct the casualty to control hemorrhage by self-aid if he is able.		
g. Communicate the medical situation to the team leader, the evaluator for EFMB testing purposes (Evaluated IAW Triage Casualties task).		
h. Tactically transport the casualty, his weapon, and mission-essential equipment to cover, as required (Evaluated IAW Evacuate Casualties tasks).		
NOTE: If the casualty has equipment that is essential to the mission, move the mission-essential equipment also. Do not try to move equipment that is not mission essential.		

i. If casualty is unresponsive, move the casualty and his weapon to cover as the tactical situation permits (Evaluated IAW Evacuate Casualties tasks).		
j. Recheck the bleeding control measures as the tactical situation permits.		
2. Perform tactical field care procedures.		
a. Immediately disarm any casualty with an altered mental status.		
b. Communicate updates to the medical situation to the unit leader in the following situations (Evaluated IAW Triage Casualties task).		
(1) Upon determining that the casualty will not be able to continue with the mission.		
(2) Before initiating any medical procedures. Ensure that the tactical situation allows for time to treat the casualty before initiating any medical procedures.		
(3) Upon any significant change in the casualty's status.		
c. Take body substance isolation (BSI) precautions.		
d. Perform an initial assessment.		
NOTE: If multiple casualties exist, at a minimum, the initial assessment will be completed on each casualty before moving to the next casualty unless they are expectant.		
NOTE: Life-threatening injuries should be treated as they are identified according to casualty triage in conjunction with the tactical situation and TCCC principles. If the casualty is expectant, move on to the next casualty.		
(1) Develop a general impression of the patient.		
NOTE: A general impression is the observation of the casualty. Note clues to the patient's mechanism of injury, the patient's approximate age, height, weight, body position, appearance, signs of distress and any odors present (i.e., urine, vomit, feces).		
(2) Determine the patient's responsiveness using the AVPU scale.		
(a) A – Alert and oriented.		
(b) V – Responsive to verbal stimuli.		
(c) P – Responsive to painful stimuli.		
(d) U – Unresponsive.		
(3) Determine the patient's chief complaint and life threats.		
NOTE: The chief complaint is the casualty's description of the injuries. Life threats are how those injuries threaten the casualty's life (i.e., an open chest wound might lead to a tension pneumothorax, which could lead to cardiac shock).		
(4) Assess for Hemorrhage.		
(a) Reassess any treatment for hemorrhage performed during the care under fire phase of care.		
NOTE: All life saving interventions must be reassessed each time the patient is moved or transported to ensure that it has not been compromised.		
(b) Perform a blood sweep to identify any life threatening hemorrhage.		
(c) Immediately treat life threatening hemorrhage, if present.		
(i) Use a tourniquet for hemorrhage that is anatomically amenable to tourniquet application (Evaluated IAW Control Bleeding with Tourniquet task).		
(ii) For hemorrhage that cannot be controlled with a tourniquet, apply a HemCon dressing or Quick Clot (Evaluated IAW Control Bleeding with Hemostatic Device task).		
(5) Assess the airway.		
(a) Perform appropriate maneuver to open and maintain the airway.		
(b) Determine if the airway is patent or not. Look, listen and feel to ensure the patient's airway is patent and not compromised.		
(c) Insert a nasopharyngeal airway adjunct, if required (Evaluated IAW Insert a Nasopharyngeal Airway task).		
(6) Assess breathing.		
(a) Inspect the chest.		

(i) Open body armor (if present) and expose the chest.		
(ii) Inspect for any penetrating chest wounds, deformities, contusions, abrasions, punctures or penetration, burns, tenderness, lacerations, swelling (DCAP-BTLS) and equal bilateral rise and fall of the chest.		
(iii) If a penetrating chest wound is present, apply an occlusive dressing to both entrance and exit wound if present (Evaluated IAW Treat a Penetrating Chest Wound task).		
(b) Auscultate at least four fields of the chest for equality and presence of respirations.		
NOTE: Successful auscultation may not be possible due to the noise on the battlefield.		
(c) Palpate the anterior area of the chest feeling for tenderness, instability and crepitus (TIC).		
(d) Apply appropriate oxygen therapy, if available.		
(e) Observe for progressive respiratory distress.		
NOTE: Progressive respiratory distress secondary to unilateral chest trauma should be considered a tension pneumothorax and requires needle decompression.		
(f) Perform needle chest decompression, if necessary (Evaluated IAW Perform Needle Chest Decompression task).		
(7) Assess Circulation.		
(a) Perform blood sweep for any additional hemorrhages.		
(i) Control bleeding, if present, with direct pressure, pressure bandage, elevation, hemostatic device, or tourniquet (Evaluated IAW appropriate Control Bleeding tasks).		
NOTE: Significant hemorrhage from an extremity wound should be stopped as quickly as possible using a tourniquet. Once the tactical situation permits, consideration should be given to applying a pressure type dressing and then loosening the tourniquet.		
(ii) Loosen tourniquet and convert to pressure dressing or use hemostatic device to control bleeding, if appropriate (Evaluated IAW appropriate Control Bleeding tasks).		
(b) Check for pulses.		
(i) Check the radial pulse, if present the blood pressure is at least 80mmHg.		
(ii) If radial pulse is not present, check for the carotid pulse. If present the blood pressure is at least 60mmHg.		
(c) Assess the skin's color, condition, and temperature (CCT).		
(d) Identify signs and symptoms of shock, if present.		
(i) Weak or absent radial pulses.		
(ii) Altered mental status.		
(iii) Pale, cool and clammy skin.		
(e) Initiate hypotensive fluid protocol (Evaluated IAW Initiate a Saline Lock and IV task).		
(i) Initiate fluids only if in hypovolemic shock.		
(ii) Give Hextend 500-ml IV bolus.		
(iii) Repeat once after 30 minutes if casualty is still in shock, not to exceed 1,000 ml of Hextend.		
(f) Prevent hypothermia and treat for shock, if applicable (Evaluated IAW Initiate Treatment for Hypovolemic Shock and Prevent Hypothermia task).		
(8) Determine the patient's evacuation priority and make a MEDEVAC decision.		
e. Perform a rapid trauma assessment.		
NOTE: Significant hemorrhage from an extremity wound should be stopped as quickly as possible using a tourniquet. Once the tactical situation permits, consideration should be given to applying a pressure dressing and then loosening the tourniquet.		

NOTE: For EFMB testing purposes, the host unit may elect for the candidate to only perform a rapid trauma assessment on one casualty due to the time required to perform this portion of the assessment.

(1) Assess the head.		
(a) Inspect for deformities, contusions, abrasions, punctures or penetration, burns, tenderness, lacerations, and swelling (DCAP-BTLS).		
(b) Palpate for tenderness, instability, and crepitus (TIC).		
(c) Use pen light to inspect eyes for pupils equal round and reactive to light (PERRL).		
(d) Inspect for raccoon eyes and battle sign behind ears.		
(e) Inspect the mouth for broken teeth or airway obstructions.		
(f) Inspect the nose, mouth and ears for cerebral spinal fluid (CSF) and/or blood.		
(g) Treat an open head wound, if present (Evaluated IAW Treat an Open Head Wound task).		
(h) Treat lacerations, contusions, and extrusions of the eye (Evaluated IAW Treat Lacerations, Contusions, and Extrusions of the Eye task).		
(2) Assess the neck.		
(a) Inspect for DCAP-BTLS.		
(b) Palpate C-spine for TIC and step-offs.		
(c) Inspect for jugular vein distention (JVD).		
(d) Inspect for tracheal deviation.		
(e) Apply cervical collar, if necessary.		
(3) Assess the chest.		
(a) Inspect for DCAP-BTLS and equal bilateral rise and fall of the chest.		
(b) Auscultate at least four fields for equality and presence of respirations.		
(c) Palpate the anterior area of the chest feeling for TIC.		
(d) Apply appropriate oxygen therapy, if available.		
(e) Observe for progressive respiratory distress.		
NOTE: A casualty with penetrating chest trauma will generally have some degree of hemo/pneumothorax as a result of the primary wound.		
(f) Perform needle chest decompression, if necessary (Evaluated IAW Perform Needle Chest Decompression task).		
(4) Assess the abdomen.		
(a) Inspect for DCAP-BTLS.		
(b) Treat an open abdominal wound, if present (Evaluated IAW Treat an Open Abdominal Wound task).		
(c) Palpate for tenderness, rigidity and distention (TRD) if no open abdominal wound exist.		
(5) Assess the pelvis.		
(a) Inspect for DCAP-BTLS.		
(b) Gently compress to detect TIC if no signs and symptoms of trauma exist.		
(c) Inspect for priapism.		
(6) Assess the lower extremities.		
NOTE: Significant hemorrhage from an extremity wound should be stopped as quickly as possible using a tourniquet. Once the tactical situation permits, consideration should be given to applying a pressure dressing and then loosening the tourniquet.		
(a) Inspect for DCAP-BTLS.		
(b) Palpate for TIC.		
(c) Check for pulse, motor, and sensory (PMS).		

(7) Assess the upper extremities.		
NOTE: Significant hemorrhage from an extremity wound should be stopped as quickly as possible using a tourniquet. Once the tactical situation permits, consideration should be given to applying a pressure dressing and then loosening the tourniquet.		
(a) Inspect for DCAP-BTLS.		
(b) Palpate for TIC.		
(c) Check for PMS.		
(d) Immobilize a suspected fracture of the arm, if present (Evaluated IAW Immobilize a Suspected Fracture of the Arm task).		
(8) Assess the posterior.		
NOTE: The casualty should be log rolled to do this portion of the assessment, unless contraindicated by injuries.		
(a) Inspect for DCAP-BTLS.		
(b) Palpate the long spine for TIC and step-offs.		
(c) Inspect for rectal bleeding.		
(d) Log roll patient onto litter/stretchers.		
(e) Reassess all life saving interventions or treatments to ensure they have not been compromised due to the movement of the patient.		
NOTE: All life saving interventions must be reassessed each time the patient is moved or transported to ensure that they have not been compromised.		
f. Perform a focused assessment.		
(1) Perform a focused physical examination of the injured or affected body part(s).		
(2) Provide interventions and treatment per triage priority.		
g. Assess vital signs.		
NOTE: If performed on a mannequin or simulated casualty, the evaluator will communicate vital signs to the candidate if assessed correctly.		
(1) Pulse.		
(2) Blood Pressure.		
(3) Respirations.		
(4) Skin color, condition, and temperature.		
(5) Pupils equal round and reactive to light.		
h. Gather AMPLE history.		
NOTE: For EFMB testing purposes, the casualty or the evaluator will communicate the AMPLE history information to the candidate if properly questioned. If the casualty is unconscious, the candidate can obtain this information from other sources (i.e., check ID tags, medication bracelets, squad members).		
(1) Allergies.		
(2) Medications.		
(3) Past prior medical history.		
(4) Last oral intake.		
(5) Events leading up to the injury.		
i. Document clinical assessments, treatments rendered, and changes in casualty's status. Forward this info with the casualty to the next level of care.		
NOTE: The EFMB host unit will standardize the method of documentation for all candidates. Documentation will be accomplished on all casualties.		
(1) Initiate a Tactical Combat Casualty Care Card (DA Form 7656) on each casualty.		
(a) Search casualty for pre-filled DA Form 7656 prior to utilizing blank form.		
NOTE: DA Form 7656 is a component of the improved first aid kit (IFAK). Soldiers may have completed name and allergies portion and inserted the form into their IFAK.		
(b) Complete all entries fully.		

(i) Write Soldier's name and unit.		
(ii) Add date and time and group. For example, 2PB on Sat, 15 Aug 2009 would be: 151400ZAUG2009.		
(iii) Write the Soldier's known medication allergies: if no allergies, record "NKDA" (no known drug allergies)		
(iv) Circle which exposure resulted in this injury [friendly; exposure unknown; or NBC (nuclear, biological, chemical)].		
(v) If a tourniquet is applied, circle "TQ" and write the time of application.		
(vi) Mark an "X" at the site of the injury(ies) on the body picture. For burn injuries, circle the burn percentage(s) on the figure.		
(vii) Circle the cause of injury [gunshot wound, blast, motor vehicle accident, other (specify)].		
(viii) Record the level of consciousness AVPU (alert, verbal stimulus, painful stimulus, unresponsive) and vital signs (pulse, respiration, blood pressure) with time.		
(ix) Circle Airway interventions [Intact, Adjunct, Cric (Cricothyrotomy), Intubated].		
(x) Circle Breathing interventions [Chest Seal, Needle D (needle decompression), Chest Tube].		
(xi) Circle bleeding control measures addressing Circulation. Don't forget tourniquet time on front of card [TQ (tourniquet), Hemostatic, Packed, Pressure Drsg (pressure dressing)].		
(xii) Circle route of fluid [IV (intravenous) or IO (intraosseous)]; type [NS (normal saline solution), LR (lactated ringers solution), Hextend]; and amount given. Specify other fluids.		
(xiii) Record the type, dose, and route of any drugs given [pain medications, ABX (antibiotics), or other].		
(xiv) Use the Other section to record any other pertinent notes and to explain any action that needs clarification.		
NOTE: When more space is needed, attach another DA Form 7656 to the original. Label the second card in the upper right corner "DA Form 7656 #2." It will show the casualty's name and unit.		
NOTE: Use only authorized abbreviations. Except for those listed below, abbreviations may not be used for diagnostic terminology. Abr W - Abraded wound. Cont W - Contused wound. FC - Fracture (compound) open. FCC - Fracture (compound) open comminuted. FS - Fracture (simple) closed. LW - Lacerated wound. MW - Multiple wounds. Pen W - Penetrating wound. Perf W - Perforating wound. SL - Slight. SV - Severe.		
(xv) The first responder will sign the card.		
(d) Attach the correctly completed TCCC Card to each casualty.		
(2) Initiate a US Field Medical Card (DD Form 1380) on each casualty.		
(a) Remove the protective sheet from the carbon copy.		
(b) Complete the minimum required blocks (1, 3, 4, 7, 9, and 11) correctly on each casualty. Complete the rest of the blocks as time permits. Attach to each casualty.		
(3) Initiate documentation using the Armed Forces Health Longitudinal Technology Application (AHLTA) or other computerized system on each casualty.		
(a) Using the AHLTA-Mobile handheld device, record data on a digital version of the DD1380 for improved readability and tracking of legible data that will be used as part of the treatment plan.		
(i) Select patient from the pre-populated data; Select DD1380; Select BI – Battle Injury Box; Tap Battle Injury checkbox; Select Injury from pop-up screen; Tap on anatomical diagram of body image at injury site; Add correct time on Time of Onset or Injury box; Click the Down Arrow; Select corresponding Injury Type; Tap Add.		
NOTE: Once injury is added treatment starts to populate at treatment box.		
(ii) Tap Vital Sign; Tap Level of Consciousness down arrow; Tap Add; Tap Close.		
(iii) Select Pain Meds/IV's; Tap Down arrow at Pain Med; Select Med; Tap Add; Tap Down arrow at IV; Tap Add; Tap Close.		

(iv) Tap Specific Treatment; Select Tourniquet box; Select Save; Select Finish; Verify DD1380 encounter; Tap Sign and Save. Candidate states requirement to sync to laptop.			
(4) Initiate documentation in another method (i.e., writing on a piece of tape placed on casualty) on each casualty.			
j. Administer appropriate medications (analgesics and antibiotics).			
NOTE: For EFMB testing purposes, the candidate will verbally state they are instructing the casualty to take or assisting the casualty in taking the Combat Pill Pack if the casualty has received a penetrating wound unless otherwise contraindicated. Actual medications will not be administered.			
(1) If able to take PO (by mouth).			
(a) Mobic 15 mg PO qd.			
(b) Tylenol, 650 mg bi-layer caplet, 2 PO q 8 hours.			
(c) Gatifloxacin 400 mg PO qd.			
(2) If not able to take PO (shock, unconscious, or penetrating torso injuries).			
NOTE: For EFMB testing purposes, the candidate will verbalize the following medications by type, amount, and route to the evaluator.			
(a) Morphine sulfate 5 mg IV/IO repeat q 10 min PRN.			
(b) Promethazine (Phenergen) 25 mg IV/IO/IM q 4 hours, for synergistic analgesic effect and as a counter to potential nausea.			
(c) Cefotetan 2 g IV or Ertapenem 1 gm IV.			
k. Package the patient and prepare for transport (Evaluated IAW Medical and Casualty Evacuation tasks).			
3. Perform ongoing assessment (while waiting for transport, repeat every 5 to 15 minutes depending on the casualty's condition), if applicable.			
NOTE: For EFMB testing purposes, the candidate will verbalize the following to the evaluator.			
a. Repeat initial assessment.			
b. Repeat vital signs.			
c. Repeat a focused assessment on all injuries and reevaluate interventions and treatments.			
d. Reevaluate the casualties' evacuation category.			
4. Perform casualty evacuation (CASEVAC) procedures (Evaluated IAW Medical and Casualty Evacuation tasks).			
5. Did not cause further injury to the casualties.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)	YES	NO
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE	DATE	

EFMB Test Score Sheet
TCCC — CONTROL BLEEDING USING A TOURNIQUET
(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)

CANDIDATE'S RANK AND NAME	CANDIDATE #
TASK: CONTROL BLEEDING USING A TOURNIQUET.	
CONDITIONS: Given a casualty who has significant extremity hemorrhage in a simulated combat environment and is under effective fire (care under fire phase) with the necessary materials to treat the casualty.	
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.	
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.	
PERFORMANCE STEPS/MEASURES	GO NO-GO
1. Take body substance isolation (BSI) precautions.	
2. Expose the wound.	
3. Apply an improvised tourniquet or Combat Application Tourniquet (CAT) to control bleeding.	
a. Improvised tourniquet.	
(1) Make a band at least 2 inches wide.	
(2) Position the tourniquet 2 – 4 inches above the edge of the wound but not on a joint.	
(3) Tie a half knot.	
(4) Place a stick (or similar object) on top of the knot.	
(5) Tie a full knot over the stick.	
(6) Twist the stick until the tourniquet is tight around the limb and the bright red bleeding has stopped.	
EVALUATOR STATES: "THE BRIGHT RED BLEEDING HAS STOPPED," AFTER CANDIDATE TWISTS WINDLASS TO AVOID INJURY TO THE SIMULATED CASUALTY.	
CAUTION: Do NOT over-tighten the tourniquet on the simulated casualty.	
(7) Secure the stick without losing positive control.	
(8) Do not cover the tourniquet.	
b. Combat Application Tourniquet (CAT).	
(1) Remove CAT Tourniquet from carrying pouch.	
(2) Slip the wounded extremity through the loop of the self-adhering band.	
(3) Position the CAT about 2 inches above the injury site.	
NOTE: If the wound is on the lower leg or the forearm, you may not be able to completely control the bleeding with the tourniquet two inches above the wound. If not, you may have to reposition the tourniquet above the knee or elbow to completely control the bleeding.	
(4) Pull the free running end of the self-adhering band tight and securely fasten it back on itself (if applying to an arm wound). Do not adhere the band past the windlass clip.	
(5) If applying to a leg wound the self-adhering band MUST be routed through the friction adaptor buckle, and fastened back on itself. This will prevent it from loosening when twisting the windlass clip.	
(6) Twist the windlass rod until bleeding has stopped.	
EVALUATOR STATES: "THE BRIGHT RED BLEEDING HAS STOPPED," AFTER CANDIDATE TWISTS WINDLASS TO AVOID INJURY TO THE SIMULATED CASUALTY.	
NOTE: Do NOT over-tighten the tourniquet on the simulated casualty.	
(7) Lock the windlass rod in place with the windlass clip.	
NOTE: For added security (and always before moving the casualty) secure the windlass rod with the windlass strap. For small extremities, continue to wind the self-adhering band across the windlass clip and secure it under the windlass strap.	
(8) Grasp the windless strap, pull it tight and adhere it to the Velcro on the windlass clip.	
(9) Do not cover the tourniquet.	

4. Place a "T" on the casualty's forehead and record the date and time the tourniquet was applied.			
NOTE: The candidate will ensure that the time the tourniquet was applied is documented and forwarded with the casualty. This will be done as standardized at the EFMB Test Site (i.e., on a DA 7656, tape applied on the casualty).			
EVALUATOR WRITES: TIME TOURNIQUET WAS APPLIED:			
5. If the tourniquet was applied on a casualty with an amputation, apply a dressing to cover the stump.			
6. Did not cause further injury to the casualty.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)	YES	NO
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE		DATE

EFMB Test Score Sheet
TCCC — CONTROL BLEEDING USING A HEMOSTATIC DEVICE
 (For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)

CANDIDATE'S RANK AND NAME		CANDIDATE #	
TASK: CONTROL BLEEDING USING A HEMOSTATIC DEVICE.			
CONDITIONS: Given a casualty who has significant extremity hemorrhage in a simulated combat environment with the necessary materials to treat the casualty.			
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.			
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.			
PERFORMANCE STEPS/MEASURES		GO	NO-GO
1. Take body substance isolation (BSI) precautions.			
2. Expose the wound.			
3. Apply a Combat Gauze.			
a. Open the sterile Combat Gauze package at either perforated edge.			
NOTE: For EFMB testing purposes, the EFMB host unit may reuse Combat Gauze or use a simulated Combat Gauze due to the high logistical cost of these items.			
b. Remove the bandage from the package.			
c. Hold the rolled bandage in non-dominant hand and identify end of gauze using fingers of dominant hand.			
d. Using dominant hand, pack Combat Gauze into wound attempting to apply pressure directly over bleeding source.			
e. Continue to pack wound with remaining gauze while maintaining pressure over wound.			
NOTE: More than one Combat Gauze may be required to control bleeding. If second dressing is required, place on top of previous dressing.			
f. Continue to apply pressure for 3 minutes or until bleeding stops.			
EVALUATOR STATES: "THE BANDAGE HAS ADHERED TO THE WOUND AND BLEEDING HAS STOPPED," AFTER CANDIDATE APPLIED PRESSURE FOR THREE MINUTES ON THE INJURY OF THE SIMULATED CASUALTY OR INSTRUCTED THAT THREE MINUTES HAVE PASSED.			
NOTE: If the bleeding has not stopped, remove the original bandage and apply direct pressure until a new bandage is in its place. Again hold pressure on the bandage for 2 to 4 minutes or until the bandage adheres to the wound and bleeding stops.			
4. Apply a pressure dressing over the combat gauze to secure it in place.			
5. Did not cause further injury to the casualty.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)		YES NO
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE		DATE

EFMB Test Score Sheet TCCC — TRIAGE CASUALTIES <small>(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCC-OP-T)</small>		
CANDIDATE'S RANK AND NAME		CANDIDATE #
TASK: TRIAGE CASUALTIES.		
CONDITIONS: Given casualties in a simulated combat environment with the necessary equipment to perform the task.		
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualties.		
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.		
PERFORMANCE STEPS/MEASURES	GO	NO-GO
NOTE: Triage establishes the order of treatment, not whether treatment is given. A primary goal is to locate and return to duty troops with minor wounds. Give available treatment first to the casualties who have the best chance of survival. Assess and classify the casualties for the most efficient use of available medical supplies.		
1. Take body substance isolation (BSI) precautions as appropriate.		
2. Assess the tactical and environment situation.		
a. Determine whether casualties must be transported to a more secure area for treatment.		
b. Determine the number and location of the injured and severity of their injuries.		
NOTE: This is a form of triage for care under fire when you are not able to visually assess the casualties' injuries. A more definitive assessment of the casualties (triage) should be accomplished when the tactical situation permits IAW performance step/measure 3.		
(1) Call out, "If you can hear my voice and can walk, move to this area now" (minimal patients). Direct the casualties to move to cover and apply self-aid if able.		
(2) Call out, "If you can hear my voice but can not walk, raise your hand and let me know" (delayed patients). Direct the casualties to "play dead" if they are unable to move and you are unable to move the casualty to cover due to direct enemy fire.		
NOTE: All casualties who do not respond should be considered either immediate or expectant.		
(3) Determine which casualties are immediate from expectant.		
c. Determine available assistance (self-aid, buddy-aid, and medical personnel).		
3. Assess the casualties and establish priorities for treatment.		
NOTE: The injuries listed under each triage category are examples. It is not all inclusive.		
a. Immediate. Casualties whose conditions demand immediate treatment to save life, limb, or eyesight. This group includes those Soldiers requiring lifesaving surgery. The surgical procedures in this category should not be time consuming and should concern only those patients with high chances of survival.		
(1) Upper airway obstruction.		
(2) Severe respiratory distress.		
(3) Life threatening bleeding.		
(4) Tension Pneumothorax.		
(5) Hemothorax.		
(6) Flail chest.		
(7) Extensive 2nd or 3rd degree burns.		
(8) Untreated poisoning (chemical agent) and severe symptoms.		
(9) Heat Stroke.		
(10) Decompensated shock.		
(11) Rapidly deteriorating level of consciousness.		
(12) Severe eye injuries.		

(13) Any other life threatening condition that is rapidly deteriorating.		
b. Delayed. Casualties who have less risk of loss of life or limb if treatment is delayed. This group includes those wounded who are badly in need of time consuming surgery, but whose general condition permits delay in surgical treatment without unduly endangering life. Sustaining treatment will be required (i.e., stabilizing intravenous fluids, splinting, administration of antibiotics, catheterization, gastric decompression, and relief of pain).		
(1) Compensated shock.		
(2) Fracture, dislocation, or injury causing circulatory compromise.		
(3) Severe bleeding, controlled by a tourniquet or other means.		
(4) Suspected compartment syndrome.		
(5) Penetrating head, neck, chest, back, or abdominal injuries without airway or breathing compromise or decompensated shock.		
(6) Uncomplicated immobilized cervical spine injuries.		
(7) Large, dirty, or crushed soft tissue injuries.		
(8) Severe combat stress symptoms or psychosis.		
(9) Severe eye injuries without hope of saving eyesight.		
c. Minimal. These casualties have relatively minor injuries and can effectively care for themselves or can be helped by non-medical personnel.		
(1) Uncomplicated closed fractures and dislocations.		
(2) Uncomplicated or minor lacerations (including those involving tendons, muscles, and nerves).		
(3) Frostbite.		
(4) Strains and sprains.		
(5) Minor head or eye injury (loss of consciousness of less than five minutes with normal mental status and equal pupils).		
d. Expectant. Casualties in this category have wounds that are so extensive that even if they were the sole casualty and had the benefit of optimal medical resource application, their survival would be unlikely. The expectant casualty should not be abandoned, but should be separated from the view of other casualties. Using a minimal but competent staff, provide comfort measures for these casualties, if available.		
(1) Traumatic cardiac arrest.		
(2) Massive brain injury.		
(3) 2nd or 3rd degree burns over 70 percent of the body surface area.		
(4) Gunshot wound to the head with a Glasgow Coma Scale of 3.		
NOTE: Provide ongoing supportive care to expectant casualties if time and condition permits; keep separate from other triage categorized casualties.		
4. Establish a triage area separating the casualties by treatment priority IAW prescribed method.		
NOTE: The host unit will standardize how the candidates will establish the triage area (i.e., "Wheel Method" with the casualties organized in a circle with the medic in the middle to better monitor and treat the casualties IAW METT-T).		
5. Collect necessary information and communicate the medical situation to the medical officer and/or unit leadership (evaluator for testing purposes).		
NOTE: The communication of the medical situation is necessary for the medical officer and/or unit leadership to provide further medical treatment and to analyze the necessity for requesting medical evacuation of the casualties.		
a. Number of casualties.		
b. Each casualty's priority for treatment determined during triage.		
c. Special equipment required to evacuate the casualties, if applicable.		
d. Number of casualties by type, litter and/or ambulatory.		
e. Casualties' nationality and status, if other than U.S. Army.		

EVALUATOR STATES: "WHAT IS THE MEDICAL SITUATION?" WHEN THE CANDIDATE STATES THEY ARE READY TO GIVE THE MEDICAL SITUATION.

EVALUATOR WRITES: THE MEDICAL SITUATION GIVEN BY THE CANDIDATE.

Number of casualties: _____

PT 1 PT 2 PT 3 PT 4 PT 5

Each casualty's priority for treatment determined during triage: _____

Special equipment required to evacuate the casualties: _____

Number of casualties by type, litter and/or ambulatory: Litter _____ Ambulatory _____

Casualties' nationality and status: _____

6. Did not cause further injury to the casualties.

REASON(S)
FOR FAILURE

DOES THE CANDIDATE WISH TO REBUT THIS
TASK? (CANDIDATE INITIALS
APPROPRIATE BOX)

YES

NO

LANE
OIC/NCIC
INITIALS

EVALUATOR'S SIGNATURE

DATE

EFMB Test Score Sheet
TCCC — CONTROL BLEEDING USING DRESSINGS
(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)

CANDIDATE'S RANK AND NAME	CANDIDATE #
TASK: CONTROL BLEEDING USING DRESSINGS.	
CONDITIONS: Given a casualty who has a bleeding wound of the arm or leg in a simulated combat environment in tactical field care conditions and the necessary materials to treat the casualty. The casualty has already been treated in the "care under fire" phase, and an effective tourniquet is in place.	
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.	
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.	
PERFORMANCE STEPS/MEASURES	GO NO-GO
1. Take body substance isolation (BSI) precautions.	
2. Expose the wound.	
3. Loosen tourniquet slowly; if brisk bleeding returns, re-tighten tourniquet.	
EVALUATOR STATES: "BRISK BLEEDING DOES NOT RETURN" AFTER CANDIDATE LOOSENS THE TOURNIQUET.	
NOTE: If using a CAT, do not remove the tourniquet, only loosen it. This allows the tourniquet to be re-applied if the hemorrhage cannot be controlled by other methods.	
4. Apply a field/pressure dressing or emergency trauma dressing to the wound.	
a. Field and pressure dressing.	
(1) Apply the field dressing directly over the wound.	
(2) Wrap the tails around the extremity.	
(3) Tie a non-slip knot over the outer edge of the dressing, not over the wound.	
(4) Check the tightness of the dressing.	
(5) Check the distal pulse to make sure that the dressing has not been applied too tightly.	
EVALUATOR STATES: "THERE IS A PULSE."	
(6) Tuck or cut excess tails from dressing.	
EVALUATOR STATES: "WOUND CONTINUES TO BLEED."	
(7) Place a wad of padding directly over the wound.	
(8) Apply a field dressing/cravat/elastic bandage on top of the padding to create a pressure dressing.	
(9) Tie a non-slip knot directly over the wound or secure elastic bandage.	
(10) Check the distal pulse to make sure that the dressing has not been applied too tightly.	
EVALUATOR STATES: "THERE IS A PULSE AND THE BLEEDING HAS STOPPED."	
(11) Tuck or cut excess tails from dressing.	
b. Emergency trauma dressing.	
(1) Open the sterile package and apply the white portion of the bandage directly over the wound.	
(2) Wrap the elastic portion of the bandage around the extremity.	
(3) Insert the elastic wrap completely into the pressure bar.	
(4) Pull the bandage tight and reverse it back over the top of the pressure bar forcing it down onto the pad.	
(5) Continue to wrap the elastic bandage tightly over the pressure bar and wound pad. Ensure that the edges of the wound pad are covered.	
(6) Secure the hooking ends of the closure bar onto the last wrap of the bandage.	

(7) Check the distal pulse to make sure that the dressing has not been applied too tightly.			
EVALUATOR STATES: "THERE IS A PULSE AND THE BLEEDING HAS STOPPED."			
5. Did not cause further injury to the casualty.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)	YES	NO
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE	DATE	

EFMB Test Score Sheet TCCC — INITIATE A SALINE LOCK AND INTRAVENOUS INFUSION <small>(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCC-OP-T)</small>		
CANDIDATE'S RANK AND NAME	CANDIDATE #	
TASK: INITIATE A SALINE LOCK AND INTRAVENOUS INFUSION.		
CONDITIONS: Given a casualty in a simulated combat environment that requires intravenous access and follow on IV fluids. Necessary materials and equipment are available.		
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.		
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.		
PERFORMANCE STEPS/MEASURES	GO	NO-GO
NOTE: For EFMB testing purposes, the candidate will start the saline lock and then convert it to an IV. Be aware that many combat injuries and conditions might normally require an immediate IV instead of establishing a saline lock first. In addition, the candidate will only be required to perform this task on one casualty.		
1. Take body substance isolation (BSI) precautions.		
NOTE: A mannequin or training aid will be used to initiate a saline lock and intravenous infusion.		
2. Prepare to establish a saline lock.		
NOTE: For EFMB testing purposes, other sizes of needles and catheters may be utilized other than those stated.		
a. Assemble and inspect the necessary equipment for defects, expiration date, and contamination.		
(1) 20 gauge IV catheter/needle x2.		
(2) 21 gauge 1 ¼" needle.		
(3) Saline lock adapter plug.		
(4) Adhesive tape.		
(5) Alcohol and Betadine® swabs.		
(6) Constricting band.		
(7) 5cc syringe.		
(8) Sterile fluid.		
b. Explain the procedure and the purpose of the saline lock to the casualty.		
c. Place the casualty in a comfortable position with the arms supported.		
d. Select catheter insertion site.		
e. Prepare the insertion site. Apply constricting band 2" above venipuncture site (tight enough to stop venous flow, but not so tight that the radial pulse cannot be felt).		
f. Clean skin with an alcohol and/or Betadine® swab in a circular motion from the center outward.		
3. Insert the saline lock.		
a. Perform the venipuncture. Hold catheter with dominant hand and remove protective cover without contaminating the needle. Hold flash chamber with thumb and forefinger directly above the vein. Draw skin below the cleansed site downward to hold the skin taut over the site of the venipuncture.		
b. Position the needlepoint, bevel up, parallel to the vein and about 1/2 inch below the venipuncture site. Continue advancing the needle/catheter until the vein is pierced.		
EVALUATOR STATES: "YOU HAVE A FLASH," IF THE CANDIDATE INSERTS THE NEEDLE CORRECTLY.		
c. When "flash" of blood enters the flash chamber, decrease the angle between the skin and needle until the angle is almost parallel to the skin, and advance further to secure catheter placement in the vein.		

d. Place pressure on the vein above the insertion site by pressing with one finger of the non-dominant hand. Release the constricting band.		
e. Remove the needle after advancing the plastic catheter into the vein.		
EVALUATOR: ADMINISTRATIVELY GAIN CONTROL OF THE NEEDLE AND PLACE IT IN A SHARPS CONTAINER.		
f. Quickly uncap and insert the male end of the saline lock adapter plug into the hub of the catheter.		
g. Apply adhesive tape to secure the hub of plastic catheter.		
h. Flush the IV catheter. Using the 21-gauge needle and 5 cc syringe filled with sterile fluid, penetrate the transparent dressing and insert the needle into the saline lock. Inject 5cc of sterile fluid into the IV catheter.		
i. Verbally state they are looking for signs of infiltration.		
EVALUATOR STATES: "THERE ARE NO SIGNS OF INFILTRATION."		
EVALUATOR STATES: "CASUALTY NEEDS FLUIDS" OR STATES REASONS WHY NEEDED (I.E., THE CASUALTY IS SUFFERING FROM SEVERE LOSS OF BLOOD, EXHIBITING ABSENT OR WEAK PERIPHERAL PULSES, AND AN ALTERED MENTAL STATUS, AND OTHER SIGNS AND SYMPTOMS OF HYPOVOLEMIC SHOCK).		
4. Convert the saline lock to a continuous infusion IV.		
a. Explain the procedure and the purpose of the IV to the casualty.		
b. Assemble and inspect the necessary equipment for defects, expiration date, and contamination (if applicable).		
NOTE: In order to conserve resources, a crystalloid solution such as lactated ringers or normal saline may be used with a notional label of Hextend® placed on the bag for EFMB testing.		
(1) Fluids, spike, drip chamber, tubing, and needle adapter. Discard them if there are cracks or holes or if any discoloration is present.		
(2) Tubing clamp. Ensure that the clamp releases and catches.		
(3) 20 gauge IV catheter/needle for insertion into saline lock; discard if it is flawed with barbs.		
EVALUATOR STATES: "THERE ARE NO DEFECTS IN THE EQUIPMENT OR FLUIDS."		
c. Prepare the equipment.		
(1) Clamp the tubing 6 to 8 inches below drip chamber.		
(2) Remove the protective covers from the spike and the outlet of the container.		
CAUTION: DO NOT TOUCH THE SPIKE OR THE OUTLET OF THE IV CONTAINER.		
(3) Insert spike into container.		
(4) Hang the container at least 2 feet above the level of the casualty's heart.		
(5) Squeeze the drip chamber until it is half full of IV fluid.		
(6) Prime tubing.		
NOTE: Ensure all air is expelled from the tubing.		
d. Clean the rubber diaphragm of the saline lock with an antiseptic wipe.		
e. Remove protective cover without contaminating the needle of the 20 gauge IV catheter/needle and insert bevel up into the rubber diaphragm of the saline lock.		
f. Place pressure on the vein above the insertion site by pressing with one finger of the non-dominant hand and remove the needle after advancing the catheter into the saline lock.		
g. Quickly uncap and insert the male end of the needle adapter into the hub of the catheter.		
h. Set the roller clamp on the IV tubing and observe the site and ensure that normal flow is occurring.		
EVALUATOR STATES: "YOU HAVE NORMAL FLOW."		
NOTE: If the IV is not patent, do not continue with the conversion. Remove the saline lock and IV catheter and establish a new IV site.		

EFMB Test Score Sheet TCCC— INITIATE TREATMENT FOR HYPOVOLEMIC SHOCK AND PREVENT HYPOTHERMIA <small>(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)</small>	
CANDIDATE'S RANK AND NAME	CANDIDATE #
TASK: INITIATE TREATMENT FOR HYPOVOLEMIC SHOCK AND PREVENT HYPOTHERMIA.	
CONDITIONS: Given a casualty in a simulated combat environment who is suffering from severe loss of blood, exhibiting absent or weak peripheral pulses, and an altered mental status, and other signs and symptoms of hypovolemic shock and the necessary materials to treat the casualty are available.	
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.	
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.	
PERFORMANCE STEPS/MEASURES	GO NO-GO
1. Reassure the casualty to reduce anxiety.	
2. Take body substance isolation (BSI) precautions.	
3. Initiate a saline lock and convert it to continuous fluid infusion IV 500-ml bolus of Hextend® (Evaluated IAW Initiate a Saline Lock and Convert to Intravenous Infusion task).	
NOTE: In order to conserve resources, a crystalloid solution, such as lactated ringers or normal saline, may be used with a notional label of Hextend® placed on the bag for EFMB testing.	
NOTE: If after 30 minutes the casualty still has no peripheral pulse or still has altered mental status, administer a second 500-ml of Hextend®. If the casualty is still in shock after this, the casualty is probably still bleeding.	
CAUTION: Do not administer more than 1,000 ml of Hextend®. This is equivalent to six liters of lactated ringers.	
4. Loosen casualty's clothing and boots.	
5. Elevate the casualty's legs above chest level, without lowering the head below chest level.	
NOTE: The casualty's legs should not be elevated without assessing for injuries that contradict this measure.	
6. Prevent hypothermia.	
NOTE: In any temperature conditions, a casualty suffering from hemorrhagic shock is prone to hypothermia and subsequent coagulopathy.	
a. Minimize exposure.	
b. Remove any wet clothing and replace them with dry clothes, if possible.	
c. Keep the casualty warm by using the Hypothermia Prevention and Management Kit (HPMK) or other methods.	
(1) Use the HPMK.	
(a) Put Thermolite Hypothermia Prevention System cap on casualty's head, under helmet.	
(b) Place the casualty on the Blizzard Rescue Blanket.	
(c) Apply Ready-Heat blanket to torso and back of the casualty.	
(d) Wrap the rescue blanket around the casualty.	
(2) If the HPMK is not available, wrap the casualty in a space blanket, survival blanket, blanket, poncho liner, body bag, or anything that will retain heat and keep the casualty dry. Use any other method to retain heat if above gear is not available.	
7. Monitor the casualty every 5-15 minutes.	
EVALUATOR WRITES: TIMES CANDIDATE MONITORS THE CASUALTY: _____	

8. Encourage the casualty to drink water, if conscious.	

9. Did not cause further injury to the casualty.					
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)		<table border="1"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO				
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE		DATE		

EFMB Test Score Sheet TCCC— INSERT A NASOPHARYNGEAL AIRWAY <small>(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)</small>			
CANDIDATE'S RANK AND NAME			CANDIDATE #
TASK: INSERT A NASOPHARYNGEAL AIRWAY.			
CONDITIONS: Given an unconscious casualty in a simulated combat environment who has a need for a patent airway and the necessary materials to treat the casualty.			
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.			
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.			
PERFORMANCE STEPS/MEASURES			GO
1. Place the casualty supine with the head in a neutral position			
2. Take body substance isolation (BSI) precautions.			
3. Assess nasal passages for apparent obstruction.			
EVALUATOR STATES: "NASAL PASSAGES ARE NOT OBSTRUCTED."			
CAUTION: Do not use the NPA if there is a clear fluid (cerebrospinal fluid) coming from the ears or nose. This may indicate a skull fracture.			
4. Select appropriately sized airway using one of the following methods:			
a. Measure the airway from the casualty's nostril to the earlobe.			
b. Measure the airway from the casualty's nostril to the angle of the jaw.			
NOTE: Choosing the proper length ensures appropriate diameter. Standard adult sizes are 34, 32, 30, and 28 French. For EFMB testing purposes, any size may be utilized, but the candidate is required to measure to select the appropriate size.			
NOTE: A mannequin or training aid will be used to insert NPA.			
5. Lubricate the tube with a water-based lubricant or tap water.			
CAUTION: Do not use petroleum based or non-water based lubricant. These substances can cause damage to the tissues lining the nasal cavity and pharynx, thus increasing the risk for infection.			
6. Insert the NPA.			
a. Push the tip of the nose upwards gently.			
b. Position the tube so that the bevel of the airway faces towards the septum.			
c. Insert the airway into the nostril and advance it until the flange rests against the nostril.			
CAUTION: Never force the airway into the casualty's nostril. If resistance is met pull the tube out and attempt to insert it into the other nostril. Most attempts to insert the NPA should be in the right nostril. If unable to insert into the right nostril, try the left. If inserting in the left nostril, the bevel will not be against the septum.			
7. Place the casualty in the recovery position.			
8. Did not cause further injury to the casualty.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)		YES NO
LANE OIC/NCIC INITIALS	EVALUATOR'S SIGNATURE		DATE

EFMB Test Score Sheet
TCCC— TREAT A PENETRATING CHEST WOUND
(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)

CANDIDATE'S RANK AND NAME	CANDIDATE #
TASK: TREAT A PENETRATING CHEST WOUND.	
CONDITIONS: Given a casualty in a simulated combat environment with a penetrating chest wound and the necessary materials to treat the casualty.	
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.	
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.	
PERFORMANCE STEPS/MEASURES	GO NO-GO
1. Take body substance isolation (BSI) precautions.	
2. Check the casualty for signs and symptoms of a penetrating chest wound.	
NOTE: Casualty will exhibit one or more of the following signs and symptoms.	
a. A "sucking" or "hissing" sound when the casualty inhales.	
b. Difficulty breathing.	
c. A puncture wound of the chest.	
d. An impaled object protruding from the chest.	
e. Froth or bubbles around the injury.	
f. Coughing up blood or blood-tinged sputum.	
g. Pain in the chest or shoulder.	
3. Expose the wound.	
NOTE: Do not remove clothing stuck to the wound.	
4. Cover the open wound immediately with a gloved hand.	
5. Check for an exit wound.	
a. Feel and/or look at the casualty's chest and back.	
b. Remove the casualty's clothing, if necessary.	
EVALUATOR STATES: "THERE IS NO EXIT WOUND."	
6. Seal the wound(s), covering the larger wound first with an occlusive dressing ("Asherman chest seal", field first aid dressing wrapper, petrolatum gauze, plastic wrap, or other occlusive material may be used).	
NOTE: All penetrating chest wounds should be treated as if they were sucking chest wounds. In an emergency, any airtight material can be used. It must be large enough so it is not sucked into the chest cavity.	
a. If using a field first aid dressing wrapper:	
(1) Cut the dressing wrapper on one long and two short sides and remove the dressing.	
(2) Apply the inner surface of the wrapper to the wound when the casualty exhales.	
(3) Ensure that the covering extends at least 2 inches beyond the edges of the wound.	
(4) Seal by applying overlapping strips of tape to three sides of the plastic covering to provide a flutter-type valve.	
(5) Cover the exit wound in the same way, if applicable, but tape the wound on all sides.	
NOTE: Assess the effectiveness of the flutter valve when the casualty breathes. When the casualty inhales, the plastic should be sucked against the wound, preventing the entry of air. When the casualty exhales, trapped air should be able to escape from the wound and out the open side of the dressing.	
(6) Dress the wound.	

(a) Place a field first aid dressing over the seal and tie the ends directly over the wound. This may negate the flutter-valve effect, so reevaluate and adjust the dressing to maintain the flutter-valve effect.		
(b) Use padding material or another dressing for pressure and stability.		
(c) Dress the exit wound in the same way, if applicable.		
CAUTION: Ensure that the dressings are not tied so tightly that they interfere with the breathing process of the flutter-type valve.		
b. If using an occlusive dressing with no organic valve:		
(1) Apply occlusive dressing to the wound when the casualty exhales.		
(2) Ensure that the covering extends at least 2 inches beyond the edges of the wound.		
(3) Seal by applying overlapping strips of tape to three sides of the plastic covering to provide a flutter-type valve.		
(4) Cover the exit wound in the same way, if applicable, but tape the wound on all sides.		
NOTE: Assess the effectiveness of the flutter valve when the casualty breathes. When the casualty inhales, the plastic should be sucked against the wound, preventing the entry of air. When the casualty exhales, trapped air should be able to escape from the wound and out the open side of the dressing.		
(5) Dress the wound.		
(a) Place a field first aid dressing over the seal and tie the ends directly over the wound. This may negate the flutter-valve effect, so reevaluate and adjust the dressing to maintain the flutter-valve effect.		
(b) Use padding material or another dressing for pressure and stability.		
(c) Dress the exit wound in the same way, if applicable.		
CAUTION: Ensure that the dressings are not tied so tightly that they interfere with the breathing process of the flutter-type valve.		
c. If using the "Asherman Chest Seal:"		
(1) Use the 4 X 4 gauze to clean and dry the area around the chest wound.		
(2) Peel off the protective paper liner, exposing the adhesive portion of the seal.		
(3) Place the chest seal directly over the wound.		
NOTE: Tape may be used to secure the edges of the "Asherman Chest Seal" if needed.		
(4) Cover the exit wound in the same way, if applicable, but tape the wound on all sides.		
NOTE: Assess the effectiveness of the flutter valve when the casualty breathes. When the casualty inhales, the plastic should be sucked against the wound, preventing the entry of air. When the casualty exhales, trapped air should be able to escape from the wound and out the open side of the dressing.		
7. Place the casualty in a sitting position or on their injured side (recovery position) during transport.		
8. Monitor the casualty.		
a. Monitor breathing and the wound seal.		
b. Assess the effectiveness of the flutter valve.		
NOTE: Assess the effectiveness of the flutter valve when the casualty breathes. When the casualty inhales, the plastic should be sucked against the wound, preventing the entry of air. When the casualty exhales, trapped air should be able to escape from the wound and out the open side of the dressing.		
c. Check vital signs.		
d. Observe for signs of shock.		
CASUALTY STARTS GASPING FOR AIR AND STATES: "I'M HAVING DIFFICULTY BREATHING." REPOSITIONING OF THE CASUALTY DOES NOT IMPROVE BREATHING.		
9. Perform a needle chest decompression if the casualty exhibits worsening shortness of breath (evaluator/casualty will indicate so). (Evaluated IAW Perform Needle Chest Decompression task).		

10. Did not cause further injury to the casualty.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)	YES	NO
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE	DATE	

EFMB Test Score Sheet
TCCC— PERFORM NEEDLE CHEST DECOMPRESSION
(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)

CANDIDATE'S RANK AND NAME		CANDIDATE #	
TASK: PERFORM NEEDLE CHEST DECOMPRESSION.			
CONDITIONS: Given a casualty in a simulated combat environment with a tension pneumothorax and the necessary materials to treat the casualty.			
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.			
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.			
PERFORMANCE STEPS/MEASURES		GO	NO-GO
CASUALTY STARTS GASPING FOR AIR AND STATES: "I'M HAVING DIFFICULTY BREATHING." REPOSITIONING OF THE CASUALTY DOES NOT IMPROVE BREATHING. THE EVALUATOR MAY ADD ADDITIONAL INFORMATION TO COMMUNICATE THE SIGNS OF A TENSION PNEUMOTHORAX.			
1. Take body substance isolation (BSI) precautions.			
2. Assess the casualty to ensure the progressive respiratory distress is due to a penetrating chest wound.			
3. Perform needle chest decompression.			
NOTE: A mannequin or training aid will be utilized to perform needle chest decompression.			
a. Expose the chest for access to insertion site.			
b. Locate the insertion site. Locate the second intercostal space (between the second and third ribs) on the anterior chest wall at the midclavicular line (approximately in line with the nipple) on the same side of the casualty's chest as the penetrating wound; approximately two-finger widths below the clavicle.			
c. Insert a large bore (14 gauge; 3.25 inch or larger) needle and catheter unit.			
(1) Removes the plastic cap from the 3.25 inch or larger 14 gauge needle and catheter unit.			
(2) Firmly insert the needle into the skin over the top of the third rib into the second intercostal space at a 90 degree angle.			
(3) As the needle enters the pleural space in the chest cavity, a "pop" will be felt, followed by a possible hiss of air escaping the chest cavity.			
EVALUATOR STATES: "YOU HEAR A POP," WHEN NEEDLE ENTERS THE CHEST CAVITY AND "YOU HEAR A HISS," WHEN AIR ESCAPES.			
WARNING: Proper positioning of the needle is essential to avoid puncturing blood vessels and/or nerves. Blood vessels and nerves run along the bottom of each rib.			
d. Withdraw the needle while holding the catheter in place. Stabilize the catheter hub to the chest wall with adhesive tape.			
EVALUATOR: ADMINISTRATIVELY GAIN CONTROL OF THE NEEDLE AND SYRINGE UNIT AND PLACE IT IN A SHARPS CONTAINER.			
4. Place the casualty in a sitting position or on their injured side (recovery position) during transport.			
5. Did not cause further injury to the casualty.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)		YES NO
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE		DATE

EFMB Test Score Sheet TCCC — TREAT AN OPEN ABDOMINAL WOUND <small>(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)</small>			
CANDIDATE'S RANK AND NAME			CANDIDATE #
TASK: TREAT AN OPEN ABDOMINAL WOUND			
CONDITIONS: Given a casualty in a simulated combat environment with an open abdominal wound without protruding internal organs and the necessary materials to treat the casualty.			
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.			
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.			
PERFORMANCE STEPS/MEASURES			GO
1. Take body substance isolation (BSI) precautions.			NO-GO
2. Position the casualty.			
a. Place the casualty on his back (face up).			
b. Flex the casualty's knees after the casualty assessment is completed.			
c. Turn the casualty's head to the side and keep the airway clear if vomiting occurs.			
3. Expose the wound.			
4. Apply a sterile abdominal dressing.			
a. Place the dressing directly on top of the wound.			
b. Secure the dressing loosely.			
NOTE: Dependent on the type of abdominal dressing being utilized, tie the dressing tails loosely in a non-slip knot at the casualty's side if applicable.			
CAUTION: DO NOT APPLY PRESSURE ON THE WOUND OR EXPOSE INTERNAL PARTS.			
c. If two dressings are needed to cover a large wound, repeat steps 3a and 3b. Ensure that the ties of additional dressings are not tied over each other.			
d. If necessary, loosely cover the dressings with cravats. Tie them on the side of the casualty, opposite that of the dressing ties.			
5. Did not cause further injury to the casualty.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)		YES NO
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE		DATE

(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)

Worksheet # 014 to construct AMEDDC&S Form 1232, 1 NOV 11

EFMB Test Score Sheet
TCCC — IMMOBILIZE A SUSPECTED FRACTURE OF THE ARM
(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)

CANDIDATE'S RANK AND NAME	CANDIDATE #
TASK: IMMOBILIZE A SUSPECTED FRACTURE OF THE ARM.	
CONDITIONS: Given a casualty in a simulated combat environment with a suspected closed fracture of the arm and the necessary materials to treat the casualty.	
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.	
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.	
PERFORMANCE STEPS/MEASURES	GO NO-GO
1. Take body substance isolation (BSI) precautions, if necessary.	
2. Check the casualty's radial pulse. If no pulse is felt, bandage and/or splint the extremity and arrange for immediate evacuation.	
EVALUATOR STATES: "THERE IS A PULSE" AFTER PULSE CHECK.	
3. Position the fractured arm by having the casualty support it with the uninjured arm and hand in the least painful position, if possible.	
CAUTION: DO NOT TRY TO REDUCE OR SET THE FRACTURE. SPLINT IT WHERE IT LIES.	
4. Immobilize the injury. Apply an appropriate treatment depending on the location of the injury and the equipment available.	
a. Use a basswood or an improvised splint for a fractured forearm.	
(1) Pad the splint.	
(2) Place the padded splint under the casualty's forearm so that it extends from the elbow to beyond the fingertips.	
(3) Place a rolled cravat or similar material in the palm of the cupped hand.	
(4) Tie the cravats in a nonslip knot in the following order and recheck the radial pulse after each cravat is applied.	
EVALUATOR STATES: "THERE IS A PULSE" AFTER EACH PULSE CHECK UNLESS OBVIOUSLY TIED TOO TIGHTLY.	
(a) Above the fracture site near the elbow.	
(b) Below the fracture site near the wrist.	
(c) Over the hand and tied in an "X" around the splint.	
(5) Tie each cravat on the outside edge of the splint.	
b. Use a wire ladder splint for a fractured humerus and for multiple fractures of an arm or a forearm when the elbow is bent.	
(1) Prepare the splint using the uninjured arm for measurements.	
(a) Bend the prong ends of the splint away from the smooth side, about 1 ½ inches down on the outside of the splint.	
(b) With the smooth side against the elbow, place one end of the splint even with the top of the uninjured shoulder.	
(c) Select a point slightly below the elbow.	
(d) Remove the splint from the arm and bend the splint at the measured point to form an "L."	
(e) Pad the splint.	
NOTE: If padding is unavailable, apply the splint anyway.	
(2) Position the splint on the outside of the injured arm, extending from the shoulder to beyond the fingertips.	

NOTE: Extend the "L" angle of the splint beyond, but do not touch the elbow of the injured arm. Extend the leg of the angle touching the forearm beyond the ends of the fingers. If the splint is too short, extend it with a basswood splint. If possible, have the casualty support the splint.

(3) Place a rolled cravat or similar material in the palm of the cupped hand.

(4) Check the radial pulse.

EVALUATOR STATES: "THERE IS A PULSE" AFTER EACH PULSE CHECK UNLESS OBVIOUSLY TIED TOO TIGHTLY.

(5) Tie the cravats in a nonslip knot in the following order and recheck the radial pulse after each cravat is applied.

(a) On the humerus above any fracture site.

(b) On the humerus below any fracture site.

(c) On the forearm above any fracture site.

(d) On the forearm below any fracture site.

(e) Around the hand and splint.

(6) Tie each cravat on the outside edge of the splint.

NOTE: If the pulse is weaker or absent after tying the cravat, loosen and retie the cravat.

c. Use a wire ladder splint for a fractured or dislocated humerus, elbow, or forearm when the elbow is straight.

(1) Prepare the splint.

(2) Position the splint on the outside of the arm against the back of the hand.

(3) Tie the cravats in a nonslip knot in the following order and recheck the radial pulse after each cravat is applied.

EVALUATOR STATES: "THERE IS A PULSE" AFTER EACH PULSE CHECK UNLESS OBVIOUSLY TIED TOO TIGHTLY.

(a) Above the injury.

(b) Below the injury.

(c) High on the humerus, above the first cravat.

(d) Around the hand and wrist.

(4) Tie each cravat on the outside of the splint.

NOTE: If the pulse is weaker or absent after tying the cravat, loosen and retie the cravat.

(5) Apply swathes.

(a) Place the arm toward the midline in front of the body. Bind the forearm to the pelvic area with a cravat. Tie the knot on the uninjured side.

(b) Apply an additional cravat above the elbow. Secure it on the uninjured side at breast pocket level.

d. Use a SAM® splint for a fractured wrist or forearm.

(1) Prepare the splint using the uninjured arm for measurements.

(a) Unroll the splint and fold in half so it is flat.

(b) Form the splint to the curvature of the forearm and roll the end to fit in the cupped hand.

(2) Place the formed splint under the casualty's fractured arm.

(3) Secure the SAM® Splint to the fractured arm using cravats or a wrap.

(a) If using cravats, tie the cravats in nonslip knots on the outside of the splint so that the splint is secured and recheck the radial pulse after each cravat is applied.

(b) If using Kerlex® or an ACE® wrap, wrap the material around the arm, secure it, and recheck the radial pulse.

EVALUATOR STATES: "THERE IS A PULSE" AFTER EACH PULSE CHECK UNLESS OBVIOUSLY TIED TOO TIGHTLY.

5. Apply an arm sling and swathe using cravats.

a. Apply the arm sling.			
(1) Insert the splinted arm in the center of the sling.			
(2) Bring the ends of the sling up and tie them at the side (or hollow) of the neck on the uninjured side.			
(3) Twist and tuck the corner of the sling at the elbow.			
NOTE: A sling should place the supporting pressure on the casualty's uninjured side. The supported arm should have the hand positioned slightly higher than the elbow.			
b. Apply the swathe.			
(1) Apply swathes to the injured arm by wrapping the swathe over the injured arm, around the casualty's back, and under the arm on the uninjured side.			
(2) Tie the ends on the uninjured side.			
6. Recheck radial pulse.			
EVALUATOR STATES: "THERE IS A PULSE" AFTER PULSE CHECK UNLESS OBVIOUSLY TIED TOO TIGHTLY.			
7. Did not cause further injury to the casualty.			
REASON(S) FOR FAILURE	DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)	YES	NO
LANE OIC/NCOIC INITIALS	EVALUATOR'S SIGNATURE	DATE	

EFMB Test Score Sheet TCCC- TREAT LACERATIONS, CONTUSIONS, AND EXTRUSIONS OF THE EYE <small>(For use of this form, see AMEDDC&S Pam 350-10, the proponent is MCCS-OP-T)</small>		
CANDIDATE'S RANK AND NAME		CANDIDATE #
TASK: TREAT LACERATIONS, CONTUSIONS, AND EXTRUSIONS OF THE EYE.		
CONDITIONS: Given a casualty in a simulated combat environment who has an eye injury and the necessary materials to treat the casualty.		
STANDARDS: Perform all steps and measures correctly without causing further injury to the casualty.		
NOTE: THIS TASK HAS BEEN MODIFIED FOR EFMB TESTING PURPOSES ONLY.		
PERFORMANCE STEPS/MEASURES	GO	NO-GO
NOTE: The EFMB host unit will determine which type of eye injury will be tested. Only one injury will be tested.		
1. Take body substance isolation (BSI) precautions.		
2. Position the casualty and remove his headgear, if necessary.		
a. Conscious--seated.		
b. Unconscious--lying on his or her back with the head slightly elevated.		
3. Examine the eyes for the following:		
a. Objects protruding from the globe.		
b. Swelling of or lacerations on the globe.		
c. Bloodshot appearance of the sclera.		
d. Bleeding.		
(1) Surrounding the eye.		
(2) Inside the eyeball.		
(3) Coming from the eyeball.		
e. Contact lenses. Ask the casualty if he or she is wearing contact lenses, but do not force the eyelids open.		
f. Extrusion (the eye is protruding from the socket).		
4. Categorize and treat the injury.		
NOTE: Torn eyelids should be handled carefully. Wrap any detached fragments in a separate moist dressing and evacuate with the casualty.		
a. Lacerations and contusions of tissue surrounding the eye.		
(1) Close the lid of the affected eye.		
(2) Cover the injury with an eye pad or a small sterile dressing.		
CAUTION: Do not put pressure on the eyeball.		
(3) Cover torn eyelids with a loose dressing.		
(4) Place a field dressing over the eye pad or dressing of the affected eye.		
b. Injury to the eyeball.		
(1) Cover the injured eyelid with a sterile dressing soaked in saline to keep the wound from drying.		
NOTE: For EFMB testing purposes potable water may be used in place of saline to moisten bandage.		
(2) Place a field dressing over the eye pad.		
(3) Cover the uninjured eye to prevent sympathetic eye movement.		
NOTE: In hazardous conditions, leave the good eye uncovered long enough to ensure the casualty's safety.		
(4) Tell the casualty not to squeeze the eyelids together.		
c. Extrusion or avulsion.		

CAUTION: Do not attempt to reposition the eyeball or replace it in the socket.		
(1) Position the casualty face up.		
(2) Cut a hole in several layers of dressing material, and then moisten it. Use sterile liquid, if available.		
(3) Place the dressing so the injured globe protrudes through the hole, but does not touch the dressing. The dressing should be built up higher than the globe.		
NOTE: If available, place a paper cup or cone-shaped piece of cardboard over the eye. Do not apply pressure to the injury site. Apply roller gauze to hold the cup in place.		
(4) Cover the uninjured eye to prevent sympathetic eye movement.		
NOTE: In hazardous conditions, leave the good eye uncovered long enough to ensure the casualty's safety.		
5. Did not cause further injury to the casualty.		
<div>REASON(S) FOR FAILURE</div> <div></div>	<div>DOES THE CANDIDATE WISH TO REBUT THIS TASK? (CANDIDATE INITIALS APPROPRIATE BOX)</div> <div></div>	<div>YES</div> <div>NO</div>
<div> <div>LANE OIC/NCOIC INITIALS</div> <div>EVALUATOR'S SIGNATURE</div> <div>DATE</div> </div>		